



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

FONDREN ORTHOPEDIC GROUP, LLP

**Respondent Name**

LIBERTY INSURANCE CORP

**MFDR Tracking Number**

M4-14-3058-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

JUNE 9, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Claim was processed and CPT code 29827 was denied charge was not reflected on the operative report. An addendum was done to reflect procedure code 29827."

**Amount in Dispute:** \$1,235.34

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The provider submitted an addendum to operative report for denied code 29827 – not documented as performed. The updated note stated 'the rotator cuff was identified and subacromial space and repaired using the ArthroWand 90 degree, as was the partial tear and repaired again with the ArthroWand...The use of thermal to repair the Rotator Cuff has no CPT code assigned. CPT warns that it is incorrect to select a code that merely approximates the service documented.'"

**Response Submitted by:** Liberty Mutual Insurance Co.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 9, 2013	CPT Code 29827	\$1,235.34	\$1,235.34

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
  - X901-Documentation does not support level of service billed.
  - B12-Services not documented in patients' medical records.
  - X133-This charge was not reflected in the report as one of the procedures or services performed.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

## **Issues**

Does the documentation support billed service? Is the requestor entitled to reimbursement?

## **Findings**

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 29827 is defined as "Arthroscopy, shoulder, surgical; with rotator cuff repair."

The requestor appended modifier "RT-right side" to code 29827

The Operative Report indicates claimant had rotator cuff tear that was repaired; therefore, the documentation supports billed service and reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 69.43.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77074, which is located in Houston, Texas therefore, the Medicare participating amount is based on locality "Houston, Texas".

The requestor billed CPT codes 29827 and 29823. These codes are in the same endoscopic family. Per Medicare Policy "When two or more endoscopies are billed that are both in the same endoscopic family, Medicare prices the highest allowed procedure at 100 percent of the fee amount. The other procedures are priced by subtracting the fee amount of the basic endoscopy from their fee amounts." The base endoscopy code is 29805.

The Medicare participating amount for code 29805 is \$478.61.

The Medicare participating amount for code 29823 is \$653.79. Therefore, since code 29823 has the lower allowance, per Medicare Policy, \$653.79 minus \$478.61 = \$175.18.

The Medicare participating amount for code 29827 is \$1,083.96.

Using the above formula, the Division finds the following:

CPT Code	Medicare Participating Amount	MAR	Total Paid	Total Due
29823	\$175.18	\$357.49	\$1,297.45	-\$939.96
29827	\$1,083.96	\$2,212.01	\$0.00	\$2,212.01
TOTAL				\$2,212.01 minus \$939.96 = \$1,272.05. The requestor is seeking \$1,235.34.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,235.34.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,235.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	<u>02/20/2015</u>
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**